PART D PAYMENT SYSTEM

*payment***basics**

On January 1, 2006, Medicare will begin a voluntary outpatient drug benefit known as Part D. A combination of stand-alone prescription drug plans (PDPs) and Medicare Advantage (MA)–Prescription Drug plans (MA–PDs) will deliver the benefit. In each of 34 geographic regions, plans will compete for enrollees on the basis of annual premiums, benefit structures, specific drug therapies, pharmacy networks, and quality of services. Plans will bear some risk for their enrollees' drug spending. Overall, Medicare will subsidize premiums by nearly 75 percent and will provide additional subsidies for beneficiaries who have low levels of income and assets. Medicare's payments to plans will be determined through a competitive bidding process, and enrollee premiums will also be tied to plan bids.

The drug benefit

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) defines a standard drug benefit under Part D and describes the conditions under which private plans (MA-PDs and PDPs) may offer alternative benefit designs. As defined by the MMA, the standard 2006 benefit will include:

- a $250 deductible;
- coverage for 75 percent of allowable drug expenses up to a benefit limit of $2,250;
- a $3,600 catastrophic limit on true out-of-pocket spending[1] (or $5,100 in total drug expenses for enrollees without supplemental drug coverage); and
- about 5 percent coinsurance for drug spending above the catastrophic limit (Figure 1).

Enrollees with standard benefits will pay the full cost of their prescriptions for drug spending greater than $2,250 but less than their catastrophic threshold. However, beneficiaries will be able to obtain their plan's discounted price for prescription drugs in this coverage gap.[2]

Plans are able to offer alternative coverage structures. For example, a plan can offer a deductible lower than $250, or use tiered copayments rather than coinsurance—provided that the alternative benefit meets certain tests of actuarial equivalence. Also, plans may offer additional drug coverage that supplements the standard benefit. Medicare payments to plans do not subsidize such supplemental coverage.

Under Part D, Medicare will provide primary drug coverage for individuals who are dually eligible for Medicare and Medicaid. Dually eligible individuals who earn incomes up to 100 percent of poverty will have no deductibles, nominal copays, and no coverage gap. Beneficiaries who do not qualify for Medicaid, but whose incomes are below 150 percent of poverty and who meet an asset test will receive full or partial coverage for premiums and cost-sharing and will not face a coverage gap.

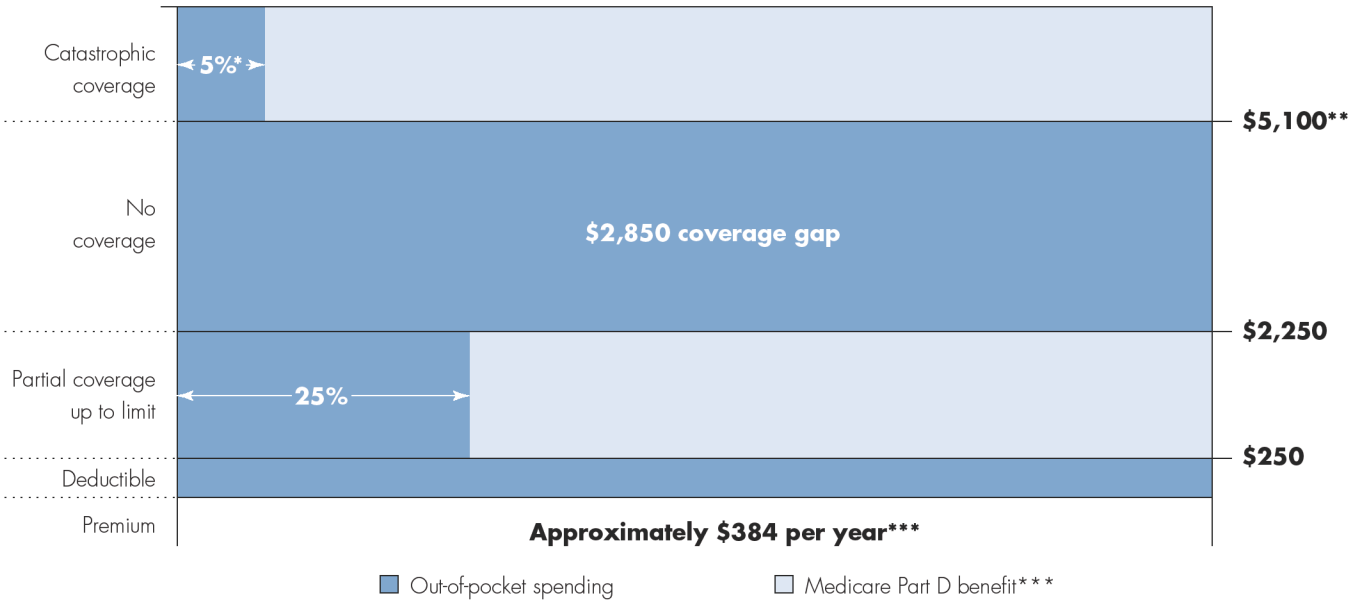
Medicare's subsidy amounts

For each Medicare enrollee in a plan (either stand-alone PDP or MA–PD), Medicare will provide plans with a subsidy that averages 74.5 percent of standard coverage for all types of beneficiaries. That average subsidy will take two forms:

- Direct subsidy—a capitated payment to plans calculated as a share of the adjusted national average of plan bids.
- Individual reinsurance—Medicare will subsidize 80 percent of drug spending above an enrollee's catastrophic threshold. Reinsurance acts as a form of risk adjustment by providing greater federal subsidies for the highest cost enrollees.

MEDPAC
601 New Jersey Ave., NW
Suite 9000
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Standard drug benefit in 2006



Note: Benefit structure applies for an enrollee who has no supplementary drug coverage.
* Cost sharing above the catastrophic cap is the greater of either 5 percent coinsurance or a copay of $2 for generic drugs, or $5 for brand-name drugs.
**Equivalent to $3,600 in out-of-pocket spending: $250 (deductible) + $500 (25% cost sharing on $2,000) + $2,850 (100% cost sharing in the "coverage gap").
***Part D enrollees pay an average of $384 per year in premiums, which is 25.5% of expected Medicare Part D benefits per person. Federal subsidies pay for the remainder of covered Part D benefits.

In addition, Medicare will establish symmetric risk corridors separately for each plan to limit a plan's overall losses or profits. Under risk corridors, Medicare limits a plans' potential losses (or gains) by financing some of the higher-than-expected costs (or recouping excessive profits). These corridors are scheduled to widen, meaning that plans should bear more insurance risk over time. Also, Medicare will pay plans that enroll low-income beneficiaries some of their enrollees' cost sharing and premiums.

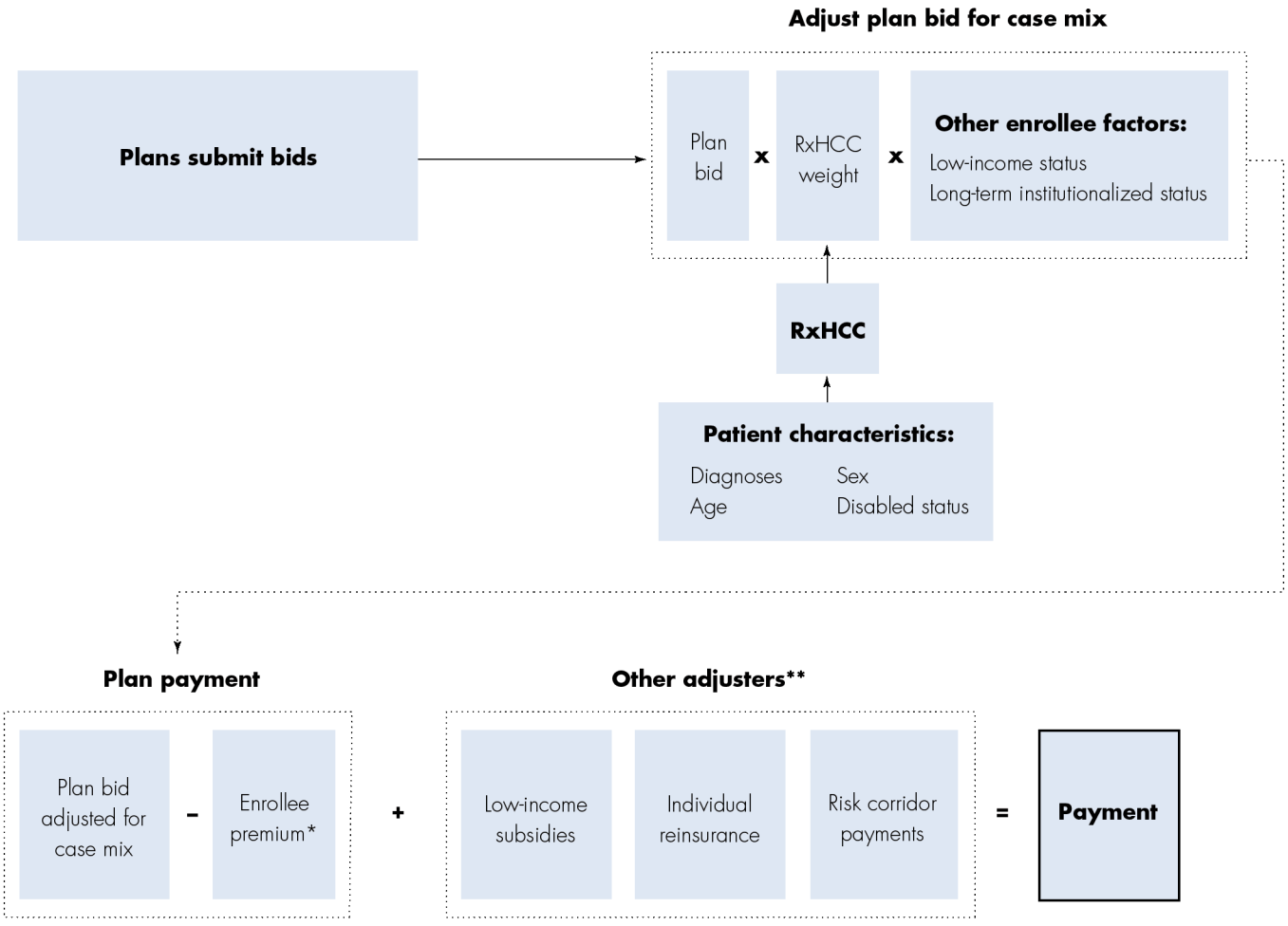
Note that although plans will get essentially the same level of direct subsidy per enrollee (modified by risk adjusters), the level of subsidies granted through the other three mechanisms could differ substantially from plan to plan. Subsidy dollars will vary depending on the characteristics of individuals that each plan enrolls (e.g., income and health status), as well as whether a plan's losses or profits trigger provisions of its risk corridors. Part D will replace Medicaid as the primary source of prescription drug coverage for individuals who are dually eligible for Medicare and Medicaid. However, states will continue to help finance the costs of drug coverage for their dually eligible beneficiaries by making monthly lump sum payments to Medicare.

Medicare's payments to plans

Each plan will submit bids annually to the Centers for Medicare & Medicaid Services (CMS) by the first Monday in June. Those bids should reflect the plan's expected benefit payments plus administrative costs after they deduct expected federal reinsurance subsidies. Plans will base their bids on expected costs for a Medicare beneficiary of average health; CMS will then adjust payments to plans based on the actual health status of the plans' enrollees.

CMS will pay plans a monthly prospective payment for each enrollee (the direct subsidy). This payment is first adjusted

Figure 2 Part D payment system



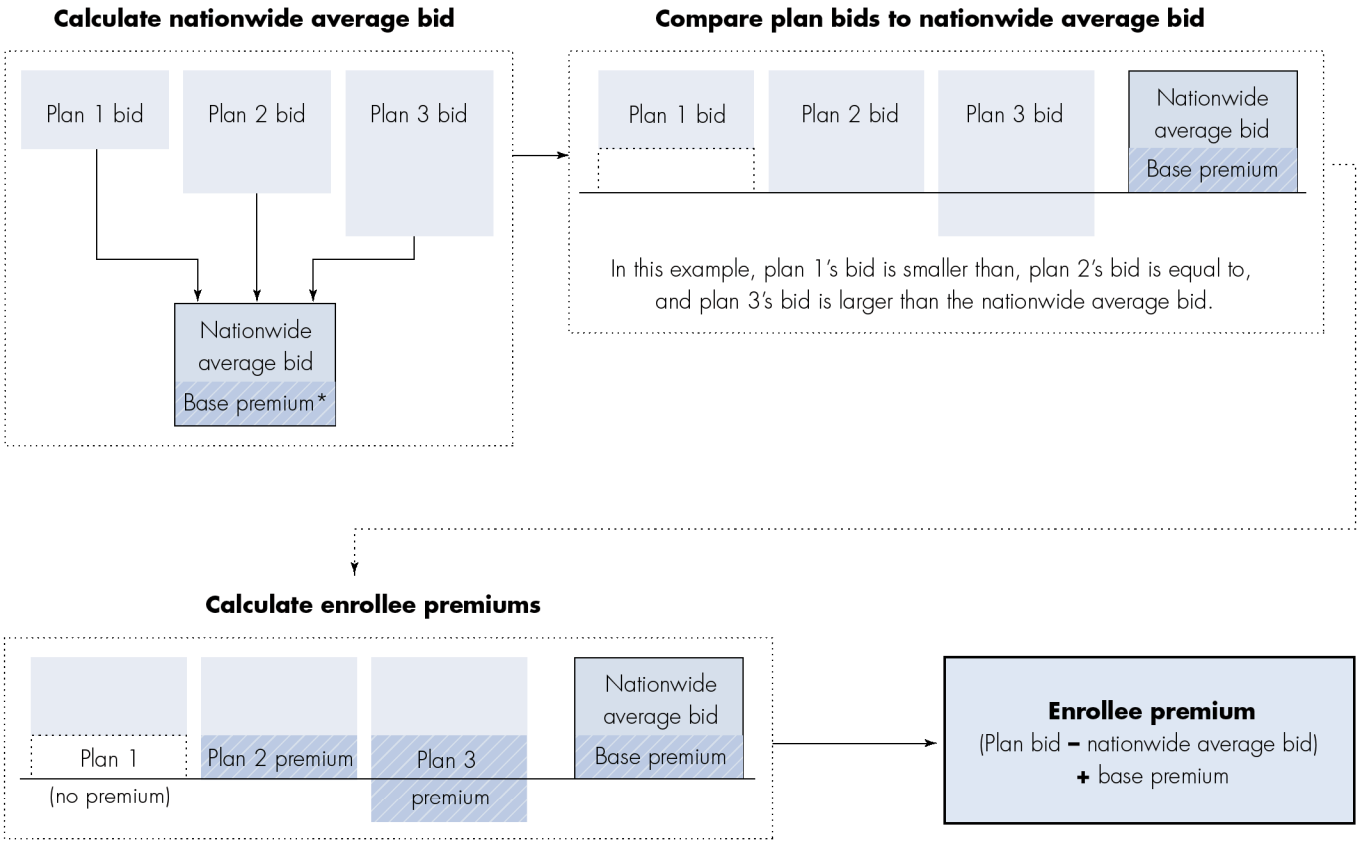
Note: RxHCC (prescription drug hierarchical condition category). The RxHCC is the model that estimates the enrollee risk adjuster.
* Figure 3 outlines the process for calculating enrollee premiums.
**Plans receive interim prospective payments for individual reinsurance and low-income subsidies that are later reconciled with CMS.

by the enrollee's risk weight and other subsidy factors, namely low-income status and long-term institutionalized status (Figure 2). A second adjustment to the plan's approved bid is the subtraction of the enrollee's premium. (See the following section on how premiums are calculated.) CMS will also provide plans with interim prospective payment adjustments for individual reinsurance and low-income subsidies. The agency will reconcile actual levels of enrollment, risk factors, levels of incurred allowable drug costs (after rebates and other discounts), reinsurance amounts, and low-income subsidies after the end of each year.

Calculating enrollee premiums

CMS takes all of the approved plan bids for standard or actuarially equivalent benefits and calculates the average, weighted by the plans' share of total enrollment (Figure 3). From this nationwide average, plan enrollees must pay a base premium ($32 in 2006) plus any difference between their plan's bid and the nationwide average bid. Thus, enrollees in costlier plans may face higher-than-average premiums for standard Part D coverage; similarly, enrollees in less expensive plans will pay lower-than-average premiums. [3]

Figure 3 Calculating enrollee premiums



Note: *Base premium is a share of the nationwide average bid. It equals the nationwide average times a factor with a numerator of 25.5% and a denominator of 100% minus CMS's estimate of aggregate plan revenues for Part D benefits that they receive through federal individual reinsurance subsidies.

Benefit and payment updates

Medicare will update the deductible, benefit limit, and catastrophic threshold amounts in the standard Part D benefit each year. Plan payments will be a function of plans' updated bids. The benefit's threshold amounts will increase by CMS's estimate of the annual change in drug spending per person. For example, CMS currently projects that by 2010, the standard benefit's deductible would be $331, the initial benefit limit would reach $2,980 rather than $2,250, and the catastrophic threshold would be $4,767 rather than $3,600 (Boards of Trustees 2005). ■

1 The term "true out of pocket" refers to a feature of Part D that directs fewer federal subsidy dollars toward enrollees who have supplemental coverage. Specifically, only certain types of spending on behalf of the beneficiary count toward the catastrophic threshold: the beneficiary's own out-of-pocket spending; that of a family member or official charity; supplemental drug coverage provided through qualifying state pharmacy assistance programs or Part D's low-income subsidies; and, under CMS's demonstration authority, supplemental drug coverage paid for with MA rebate dollars.

2 Beneficiaries also need to adhere to their plan's formulary, prior authorization, and formulary exceptions processes in order to receive credit for their out-of-pocket spending toward the $3,600 catastrophic limit.

3 Beneficiaries who delay enrolling in Part D until after their initial enrollment period and who do not have creditable coverage must also pay a late enrollment penalty similar to that for Part B. Creditable coverage refers to prescription drug benefits through sources such as a former employer that are at least as generous as the standard Part D benefit.